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End of Life Care in English Care Homes: Governance, Care Work and The Good Death

15th ESA Conference 2021
Barcelona (Online)
31st August -
3rd September 2021

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Governance

- Custody \neq Keeping alive

- Reducing costs
(to the NHS and care providers)

- Senior staff's *prediction work*
- *Anticipatory prescribing* of EOL medication by the GP

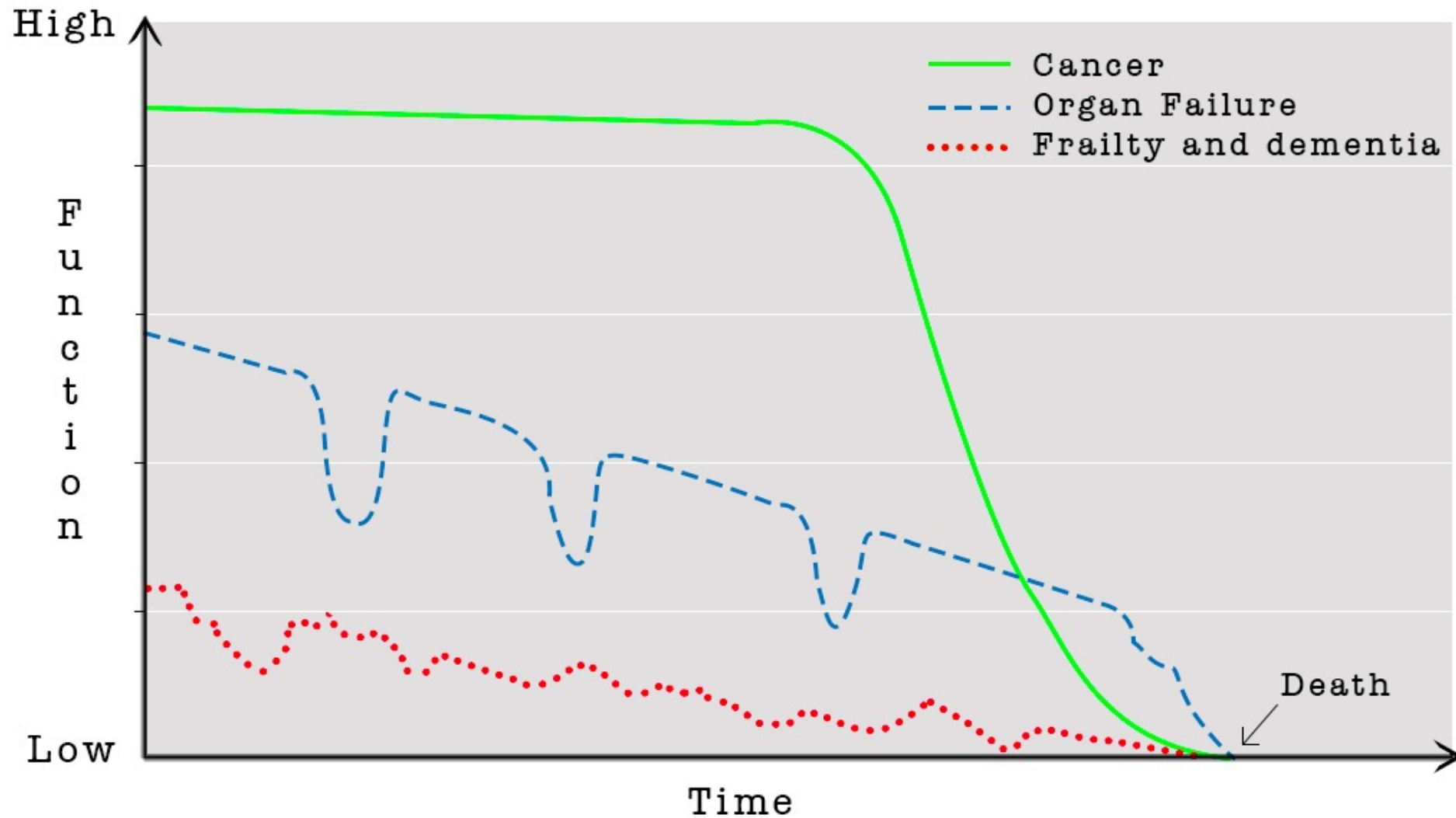
- workload increase & understaffing

- Death in the care home
vs
in hospital


- (1) prioritization of bodily care, (2) extension of residents' dying, (3) construction of death as natural (intervention & non-intervention vs accidents & neglect)

- **The good death is the regulations-complying death**
> Coroner's + CQC

The three typical end-of-life trajectories (Teggi, 2018)



Care Work

- Carers wanted to improve residents' lives, but the care home system (governance) was not geared towards this.
- Bed and body work
-  Emotional work
- instrumental vs non-instrumental
- *'Being with'* residents at the end of life (EOL) countered social death.
- The *predicament of care work* in care homes was compounded at the EOL.



The Good Death

	DOMINANT GOVERNANCE-MANDATED	AUXILIARY STAFF-IMPLEMENTED
MEDICAL	Death is predicted and managed by senior staff, GPs and DNs: death occurs in the care home and is pain-free.	
NATURAL (a misnomer)	Death from illness or deterioration (causes internal to residents' bodies) as opposed to accidents (falls, injuries, choking on food/drink) or a resident's decision to self-dehydrate/starve (causes external to residents' bodies). Natural death is both the product of intervention and non-intervention . Sudden natural deaths are problematic because unpredictable.	
SACRED	Death is expected by the relatives/close companions of the dying resident.	Death is accompanied by the carers (and/or relatives) of the dying resident.

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